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ABSTRACT

This review identifies two areas of therapist in-session functioning that contribute to positive psychotherapy outcome. The first area discussed is therapist interpersonal characteristics, or non-specific factors, and therapist interventions that contribute to establishing and maintaining a therapeutic alliance. Alliance has been shown in psychotherapy outcome research to be correlated to positive therapy outcome. The second area discussed is therapist interventions that contribute directly to positive psychotherapy outcome. Implications for therapist functioning both as a result of characteristics and interventions are discussed. Research in this document suggests that: (1) an active collaborative involvement in therapy by patients and the patient's positive experience of the therapist's relationship qualities are essential for successful psychotherapy outcome; (2) establishing and maintaining a strong working alliance between patient and therapist is necessary for successful therapy outcome; (3) therapists contribute to successful outcome through offering a relationship based on warmth, friendliness, genuine caring, understanding, and acceptance; and (4) therapists can further facilitate successful outcome by providing a consistent and purposeful approach and by considering the level of psychological maturity of the client. Contains 45 references. (Author/SR)

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THERAPIST IN-SESSION FUNCTIONING THAT POSITIVELY AFFECTS PSYCHOTHERAPY OUTCOME

by

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THERAPIST IN-SESSION FUNCTIONING THAT POSITIVELY AFFECTS PSYCHOTHERAPY OUTCOME

A Doctoral Research Paper

Presented to

the Faculty of the Rosemead School of Psychology

Biola University

In Partial Fulfillment

of the Requirements for the Degree

Doctor of Psychology

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by

Columbus B. Bryant IV

May, 1995

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ABSTRACT

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This review identifies two areas of therapist in-session functioning that contribute to positive psychotherapy outcome. The first area discussed is therapist interpersonal characteristics, or non-specific factors, and therapist interventions that contribute to establishing and maintaining a therapeutic alliance. Alliance has been shown in psychotherapy outcome research to be correlated to positive therapy outcome. The second area discussed is therapist interventions that contribute directly to positive psychotherapy outcome. In the review implications for therapist functioning both as a result of characteristics and interventions are discussed.

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THERAPIST IN-SESSION FUNCTIONING THAT POSITIVELY AFFECTS PSYCHOTHERAPY OUTCOME

Introduction

This review surveys one segment of the research literature on the process of psychotherapy, specifically those factors or variables that measure the effect of therapist in-session functioning. The purpose of the review is to understand more clearly what therapists contribute in the process of therapy that positively affects outcome in order to provide guiding concepts for the practice of psychotherapy.

Methodological Considerations

Research on psychotherapy can be generally divided into two categories. There are studies that investigate the efficacy of psychotherapy, usually a particular modality or theoretical approach, and there are studies that investigate factors in the process of psychotherapy and their contribution to efficacious outcome. The former category of studies generally follows a traditional research design where a particular type of treatment is offered to a large number of patients. Another group of patients not offered the particular type of treatment is used as the comparison group or control group. In some cases the control group is on a waiting list for treatment or receiving minimal treatment. In other cases the control group may receive a different type of treatment. The goal of the study is to compare the outcome of the research group with the control group to see if the type of treatment being researched contributes to positive outcome.

Studies of the latter category, the process factors or process variables, are usually designed in a different way. The most striking difference is the absence of a control group. Thus, the goal of these studies is to see if there is a correlation between the process factors, which are the independent variables, and the outcome factor, which is the dependent variable. One reason for eliminating the control group is that the process variables being studied are often aspects of all treatment, regardless of theoretical orientation, and thus cannot be eliminated in order to form a control group. However, without a control group, it is more difficult to determine if it is the process variable being studied that is actually contributing to outcome or some other factor or factors making the contribution. Even if a correlation is found, it is difficult to be sure about the direction of the correlation. In other words, does the independent variable affect the dependent variable or is it affected by the dependent variable. These two limitations, the lack of a control group and uncertainty about the causal direction of the correlation, are primary criticisms of the research methodology used in the studies reviewed in this paper. In addition, there are further limitations to correlational research methodology that will be discussed.

Of the correlational studies reviewed here, there are two main subcategories. The first type called intersubject studies measure the effect of process variables across subjects. In these studies there usually are a large number of cases in which the process variable being studied is measured to see if there is a statistical correlation between it and a specific outcome variable across all cases. There may or may not be a control group. In the second category of studies called intrasubject studies, or single case studies, the focus is on the variation in effect over time reflected by repeated measurement of the process variable in the same case. The variable can take on only one value at a specific

point in time within an individual. Rather than studying a large number of subjects and the aggregate effect of the process variable across subjects, in this type of study there is a repeated measurement of the process variable within one patient's treatment. The repeated measurements of the variable are evaluated in terms of their affect on the outcome variable being studied. Generality of outcome of one's findings is addressed by replicating the research on a case-by-case basis.

There are difficulties with designing sound correlational research studies. First, the process variable has to be clearly defined conceptually and closely connected with a theoretical hypothesis of change. This may be difficult as even within theoretical orientations there is not always agreement on the definition of particular technical processes or on which elements are essential in the process of change. To the degree that there is agreement about elements of change and agreement about what these elements/factors look like in process, it is easier to isolate and study the effect of these factors and to replicate studies using them.

The second challenge to correlational research designs is the accurate measurement of the factors/variables being studied. The development of a measure for a process variable is complicated. The goal of the measure is to bridge the gap between the definition of the variable and the variable in actual process in a way that reliably identifies each when they occur in reality. The reliability of the research findings is dependent on the accuracy of the measurement tool. Closely connected with this issue is the consistency of persons using the measurement tool. Judges or raters need to be both consistent in their use of the instrument and consistent when compared to the use of the instrument by other judges.

The third issue is the context or timing within the progression of treatment in which the process variable being measured occurs. The effect of the variable on a patient is not always equal each time it occurs in treatment and this effect is influenced by other factors. Some of these influencing elements are patient factors such as capacity for insight and experiencing, mastery of problems, and the overall way in which the patient processes information including the influence of the patient's self image and view of the world. Other influences include the phase of treatment in which the variable occurs. Examples of these phases include establishing the alliance, defining the problem, working through, or termination of treatment (Marmar, 1990). The effect of the variable is also influenced by the strength of alliance in the treatment relationship, the intended and understood meaning in the communication surrounding the use of the variable, and the content being discussed when the variable occurs, particularly the extent to which the content concerns the patient's prominent relationship and/or intrapsychic themes.

Fourth is the issue of whether it is most important to measure the immediate impact of the variable or to measure the aggregate effect of the variable on the patient's treatment outcome. In a single case design the emphasis is on the immediate impact of patient experiencing and functioning. Consequently there is higher confidence that it is the effect of the variable being measured and not the effect of other unmeasured and thus complicating factors that influences patient experiencing or functioning. Studies that measure the aggregate effect of the variable are attempting to correlate this effect with certain measures of treatment outcome.

Finally, there is the issue of appropriate data analysis. The challenge here is threefold. First, the goal is to isolate the process variable in order to evaluate

the extent to which it is correlated with outcome. The second goal is to evaluate the percent of effect on outcome the variable has compared to other variables. The third goal is to understand the direction of influence between the independent, process variable and the dependent, outcome variable.

In summary, the criteria for a good correlational study can be described as follows. The variable being measured is closely linked with a specifically defined concept and a clear theoretical hypothesis on the process of change. After defining the variable, a measurement instrument is needed that reflects accurately the definition and is sensitive to identifying when the variable occurs. Third, the measurement instrument should be consistent in measurement of a variable across both repeated uses by the same judge and across repeated uses by different judges. This consistency is not only dependent on the instrument's reliability but also on adequate training and experience in the use of the instrument by judges. Fourth, a well designed study will take into consideration the effect of the variable as it is influenced by the context in which it occurs. Fifth, whether the study is to measure the immediate or overall/aggregate effect of the variable must be considered and decided upon by the researcher. Sixth, appropriate and effective data analysis techniques must be chosen that measure both the extent in effect of the variable and the direction of influence between the independent variable and the dependent variable. Finally, an effective study should eventually allow for replication.

Context For This Review

A comprehensive review of psychotherapy research was done by Luborsky, Auerbach, Chandler, Cohen, and Bachrach (1971). They identified four main areas of research on psychotherapy: patient factors before

psychotherapy, therapist factors before psychotherapy, the match between patient and therapist, and treatment factors. At that time the only research reported by Luborsky et al. (1971) about therapist in-session functioning was on the effect of therapist empathy and related qualities of warmth and genuineness on outcome. These qualities are often referred to as the non-specific factors in the therapy process and are well documented in articles by Truax et al. (1966) and Frank (1974). Research concerning specific therapist in-session functioning that could be distinguished from these "non-specific" factors was not available. In a similar review, Kilmann, Scovern, and Moreault (1979) concluded that the area of specific therapist in-session functioning was still an under researched area.

It is well documented in both the theoretical and research literature that the alliance between client and therapist accounts for a substantial amount of the variance in the outcome of psychotherapy. The alliance is often thought to be affected most by the aforementioned non-specific factors. In this review the interest is to find any particular areas of therapist functioning that contributes to the establishment, building, and maintenance of the alliance; as well as areas of functioning that positively affect outcome without a necessary mediating influence from the alliance. This distinction is somewhat arbitrary as all functioning, even the presence of the therapist, affects the alliance. However, some studies do attempt to establish independence of variables measuring therapist functioning from the alliance variables, and attempt to evaluate their direct contribution to treatment outcome.

The available literature on process variables addresses the effect on treatment outcome of both the alliance between patient and therapist, and the patient and therapist in-session functioning. Specifically the literature addresses: (a) the relationship between the alliance and outcome, (b) patient functioning

that contributes to establishment and maintenance of the alliance, (c) therapist functioning that contributes to establishment and maintenance of the alliance, (d) patient functioning that contributes to outcome independent from alliance, and (e) therapist functioning that contributes to outcome independent from alliance. These five areas are illustrated in the following table.

Table 1

Categories of Research on Process Variables in Psychotherapy

a.	Alliance	——>		Affect	——>		Outcome	
b.	Patient Function	—>	Affect	—>	Alliance	—>	Affect	—> Outcome
c.	Therapist Function	—>	Affect	—>	Alliance	—>	Affect	—> Outcome
d.	Patient Function	——>		Affect	——>		Outcome	
e.	Therapist Function	——>		Affect	——>		Outcome	

Table 1 provides the specific context for the review that follows. Studies will be generally grouped in two ways. First, studies that consider the therapist contribution to building and maintaining the alliance, category C in Table 1, will be grouped under the section Therapist Contribution to Alliance. Second, studies considering therapist in-session functioning and its direct affect on outcome, distinguishable from alliance building variables, will be grouped under

the section Therapist Interventions. This group of studies is represented as category E in Table 1.

Therapist Contribution to Alliance

Patient Involvement and Patient Perception of Therapist

Strupp and Hadley (1979) found a conjunction between a patient's ability to take advantage of the healing effects of a benign human relationship, and the therapist whose interventions were experienced by the patient as an expression of caring and genuine interest. In this study, the ability of the patient to utilize the patient/therapist relationship, and the experience by the patient of the therapist's relationship qualities were found to be primary variables in successful outcome. The results are congruent with the conclusions of Truax et al. (1966) and Frank (1974) who found nonspecific factors to be primary determinants of outcome, at least from the standpoint of the therapist's contribution. The report states that while techniques of the therapist did not give rise to measurably superior treatment effects, techniques and therapist skills appear to potentiate the natural healing process of a good human relationship provided the patient is motivated, that is has a low resistance to change, and is able to feel comfortable with the therapist's approach to therapy. The techniques referred to are not clearly defined but appear to be skills having to do with promoting and strengthening the therapeutic alliance or with "potentiating therapeutic gains" in individuals who are highly motivated (Strupp and Hadley, 1979, p. 1135). In summary, Strupp concluded that the outcome of psychotherapy is influenced by the interpersonal process between patient and therapist more than the technical interventions by the therapist. The positive effect of this process on outcome is influenced more by the patient's ability to utilize the relationship and their

experience of the therapist's relationship qualities than the therapist's actual functioning and qualities. While this study lends evidence to the positive effect on outcome of a good therapy alliance, it gives little insight into areas of purposeful functioning by the therapist that will contribute to positive outcome. It argues more for the importance of therapist maturity than therapist technical skill as the critical contributing factor to positive therapy outcome.

Windholz and Silberschatz (1988) replicated the Strupp and Hadley (1979) research. When therapists rated outcome, there was a positive correlation between patient involvement, and the Global Assessment Scale scores and overall change (r = .43 and r = .44; $p < .01$); and therapist offered relationship, and the Global Assessment Scale scores and target complaints (r = .41 and r = -.45; $p < .01$). Neither patient ratings nor independent evaluator ratings showed correlations between the three variables being studied (patient involvement, therapist offered relationship, and exploratory processes) and any of the three outcome measures being used (change on the Global Assessment Scale, overall change, and target complaints). Without confirmation from patient and independent rater evaluations that these two variables are correlated with positive outcome, the validity of therapist ratings becomes questionable. Exploratory processes, which involve specific therapist technique and interventions, were not correlated with positive outcome supporting the findings of Strupp and Hadley (1979). In this study it is the interpersonal process itself contributed to by both patient and therapist, not therapist technical skill, that positively affects outcome.

Bottari and Rappaport (1983) also found that good therapeutic alliance positively affects outcome of treatment. In this study the initial therapy session was rated by both the therapist and the patient. Each one reported on his/her

feelings, and his/her view of the other's style of relating. In addition, the patients rated their degree of satisfaction with the session. An analysis was done to assess the relationship between the initial process in session one and the outcome of treatment. In the findings, patients who perceived their therapist's affective condition to be more positive during the initial session demonstrated greater symptomatic improvement after four sessions. The more positively the patient assessed the therapist's style of relating, the greater the number of attended sessions. The findings indicate that it is the patient's perception of the therapist's functioning during the first meeting that related significantly to the outcome, both in terms of symptom improvement and number of sessions attended. This finding is similar to the findings of Strupp and Hadley (1979). In this study by Bottari and Rappaport (1983) it would have been beneficial if there had been an analysis conducted to compare the patient's perceptions of therapist functioning to that of ratings by independent observers of therapist functioning. Then it could be seen whether or not their perceptions matched particular behaviors or characteristics of therapists as judged independently. This would help to identify specific aspects of therapist functioning that can lead to the patient's positive perception of the therapist's style of relating. In terms of understanding therapist functioning and contribution to the therapeutic relationship, this study is limited by its use of only patient perspective on the therapist's style of relating.

Gomes-Schwartz (1978) participated in the same study with Strupp and Hadley (1979) but analyzed a different set of data. In this study, the same three process dimensions, patient involvement, therapist offered relationship, and exploratory processes, were compared in terms of their effect on outcome. Therapist offered relationship was defined as the therapist's warmth and

friendliness. Exploratory processes were defined as the patient's level of self-examination and exploration of feelings and experiences, and the degree to which the therapist attempted to examine the psychodynamics underlying the patient's problems. These dimensions represent what the patient brings to treatment and how the patient functions in treatment, the relationship qualities of the therapist in-session, and a specific function of the patient and therapist in-session relationship. From the perspective of the therapists and independent judges, patient involvement was found to be more significant in terms of overall outcome rating ($R = .56$; $p < .01$ and $R = .54$; $p < .01$) and in terms of resolution of presenting target complaint ($R = .63$; $p < .001$) than was exploratory processes and therapist offered relationship. Patient involvement in the therapeutic process accounts for up to 38% of the variance in treatment outcomes as rated by therapists and independent judges. This variable bore a more significant relationship to the outcome than did the other two process dimension variables. Patient involvement was consistently the most highly correlated with outcome, even exclusive of the influences of both therapist-offered relationship and exploratory processes.

While patient involvement was the most highly correlated variable in relation to positive outcome, there was a significant correlation between the variable of therapist offered relationship and positive outcome ($R = .51$; $p < .01$), accounting for 24% of the variance in change of target complaints; and between exploratory processes and outcome ($R = .45$; $p < .05$) accounting for 18% of the variance in positive overall treatment outcome. These correlations were found from the rating perspective of the therapist only. It is disappointing that ratings by patients and independent judges did not produce significant correlations with positive outcome for these two variables.

If the therapist perspective is trusted to represent real effects, Gomes-Schwartz (1978) establishes that therapist functioning beyond the non-specific relationship factors can influence treatment outcome in a positive way, given patient involvement. More research is needed to specify types of interventions that contribute to positive outcome. As will be seen in this review, the research has defined several types of interpretative interventions. Examples are the exploratory processes variable in Gomes-Schwartz (1978), interpretation of intra-psychic or underlying psychodynamics, interpretations concerning the patient's interpersonal or object world outside of therapy, and transference interpretations which involve the patient in relation to the therapist and/or therapy. Gomes-Schwartz (1978) is limited due to considering only the first type.

Kolb, Beutler, Davis, Crags, and Shanfield (1985) found that therapist ratings of the patient involvement in the treatment process were particularly and strongly related to various therapeutic outcomes. Therapist ratings of patient involvement and patient pretherapy extroversion scores were significantly related to patient ratings of positive change ($R = .65$). Therapist ratings of patient involvement in treatment were related to therapist ratings of patient improvement ($R = .81$). This supports the outcome of the Gomes-Schwartz (1978).

The studies in this review prior to Kolb et al. (1985) did not attempt to identify aspects of therapist functioning that correlates with patient involvement. Kolb et al. (1985) attempted to establish this which makes it an important study given the research question of this review. Therapist ratings of the level of directive support provided for patients positively correlated with therapist ratings of patient involvement ($r = .32$; $p < .05$). Patient ratings of therapist facilitative skill positively correlated with therapist ratings of patient

involvement ($r = .40$; $p < .01$). This suggests that the influence of therapist directive support and facilitative skill on outcome is through its impact on patient involvement, and that these therapist variables are most influential with extroverted patients. By positively affecting patient involvement, treatment outcome is in turn positively affected.

Due to the nature of correlational research, it is difficult to determine if therapist direct support and facilitative skill influenced patient extroversion and involvement, or if patient extroversion and involvement influenced the two types of therapist functioning and/or patient perception of therapist functioning. It would have been helpful had Kolb et al. (1985) compared the correlations they found with patients low on extroversion and involvement, particularly early in treatment, and therapists rated by patients or independent judges to be high on directive support and facilitative skill. Also to have a comparison of patients high on the two patient variables and therapists low on the two therapist variables, particularly early in treatment, would have been helpful. These different combinations could provide information to help determine the causal direction in the correlation between therapist functioning and patient involvement.

Cooley and Lajoy (1980) used five factors previously identified in research by Lorr (1965). The study by Lorr (1965) was designed to study what patients perceive as helpful from therapists in a therapy relationship. Cooley and Lajoy (1980) repeated and extended Lorr's study to evaluate not only the patient's perception of what is helpful but also to evaluate the therapist's perception of the therapeutic relationship. The hypothesis of the study was that patient and therapist perception of what is helpful would be similar and that what they perceived to be helpful among the five factors would be correlated with positive

outcome. The five factors concerning therapist characteristics and functioning were Understanding, Acceptance, Authoritarian (Directive), Independence-Encouraging, and Critical-Hostile. In Lorr's study, Understanding and Accepting were related most significantly to patient and therapist rated improvement by patients in treatment.

When patients were rating outcome, the therapeutic qualities judged to be most correlated with total improvements were again Understanding (r = .49; p < .01) and Accepting (r = .43; p < .01). The ratings by therapists most positively correlated with four different measures of outcome were Understanding (range: r = .35-.55; p < .01), Acceptance (range: r = .33-.34; p < .05 and r = .40-.41; p < .01), and Independence-Encouraging (range: r = .27-.34; p < .05) for four patient rated and two therapist rated outcome measures. This data supports the idea that it is the non-specific relationship variables, Understanding and Acceptance, that most positively effect the outcome of treatment, at least in comparison to the other variables being studied. In addition, therapist rating of Independence-Encouraging was correlated with positive outcome on two of four outcome measures. The data indicates that the greater the agreement between the patient and the therapist on the factors of Understanding and Acceptance, the greater the reported improvement.

Establishing and Maintaining Alliance

Marziali (1984b) used a system of three measurements of patient and therapist contribution to the therapeutic relationship. She had the patient, the therapist, and judges complete measures independently concerning the therapeutic relationship. Ratings by patients of patient and of therapist positive alliance behavior correlated significantly with a decrease in general symptoms (r = -.34; p < .05 and r = -.30; p < .05), and with improvement on the outcome

measures of patient evaluation (r = .57; p < .001 and r = .45; p < .01), therapist evaluation (r = .43; p < .01 and r = .29; p < .05), clinical evaluation of dynamic outcome (r = .38; p < .01 and r = .47; p < .01). Ratings by therapists of patient and of therapist positive alliance behavior correlated significantly with a decrease in general symptoms (r = .-37; p < .01 and r = -.30; p < .01), and with improvement on the outcome measures of patient evaluation (r = .52; p < .001 and r = .32; p < .05), and therapist evaluation (r = .51; p < .001 and r = .32; p < .05). Independent judge's ratings of patient positive alliance behavior were correlated with positive outcome on the outcome measures of patient evaluation (r = .59; p < .001), therapist evaluation (r = .48; p < .01), and clinical evaluation of dynamic outcome (r = .25; p < .05). Independent judge's ratings of therapist positive contribution to alliance were positively correlated with the outcome measure of patient evaluation (r = .30; p < .05). The patient's positive and negative contributions to the alliance were consistently the best indicator of outcome in the expected directions, that is, positive contributions leading to positive outcome and negative contributions leading to negative outcome, compared to therapists' positive and negative contribution to the alliance. This supports the findings of Gomes-Schwartz (1978) that patient involvement accounts for the highest percent of the variance in positive outcome; and in this study also negative outcome. Similarly, therapist positive contribution to the alliance, while not as significant, still was significantly correlated with positive outcome. Positive and negative alliance behaviors were independent of each other in the findings, meaning that, for example, a patient's positive rating of therapist behavior did not preclude him or her from also recognizing negative alliance behavior by the therapist. Apparently, for positive therapy outcome, the overall balance of behavior needs to be in the favor of positive alliance by both the

patient and the therapist, with the patient's contribution being more significant. A deficit of this study is that it did not clearly define positive or negative alliance behavior. Defining these concepts, particularly therapist alliance behavior, would have been helpful for the purposes of this review.

Also implied in the findings of Marziali (1984b) is the fact that the treatment relationship is an ever shifting and at times ambivalent process. Buckley, Conte, Plutchik, Wild, and Karusu (1984) found that high levels of fluctuations in the alliance, and lack of the patient reaching a stable identification with the therapist, had significant negative correlations with outcome. Consequently the task of therapist and patient in treatment is that of continually restoring the positive alliance so that a working relationship can be maintained. In addition, the study concluded that typically there is lower positive alliance in early sessions than in latter sessions. The alliance builds in a positive direction in cases of successful outcome. The first three to five sessions reflected more tentative interactions in terms of positive alliance. Working through of early relationship conflicts in treatment is very influential in achieving a predominantly positive alliance and consequent positive outcome. The shortcoming of this study is its failure to specify the positive and negative alliance behaviors by the therapist in specific terms that would allow for development and further study of therapist variables that contribute to positive alliance.

Henry, Schact, and Strupp (1986) found that in high change cases, therapists were significantly more affirming and understanding, helping and protecting, and less belittling and blaming. High change cases were characterized also by greater positive complementary. Complementary is defined as a respondent acting in a manner that is pulled for by the evoking style

of the other, as opposed to feeling pressured by hostile/negative feelings and responding with controlling behavior. This involves patients responding in a way that follows the therapist's eliciting characteristics and behaviors, such as those mentioned above. As might be expected, a low level of negative or hostile communication on the part of the therapist was indicated in high change cases. In addition, a low level of multiple communications was present in high change cases. Multiple communications were defined as a single thought unit communicating more than one interpersonal message. An example given was "a message that simultaneously communicates acceptance and rejection" (Henry et al., 1986, p. 30).

Coady (1991a) found that when compared to patients with poor therapy outcome, therapists of patients that had positive therapy outcome were significantly more helping and protecting. The study did not find a significant correlation between the variable affirming and understanding and positive therapy outcome. Coady (1991a) points out that the variable affirming and understanding involves affiliative behavior by therapists. The variable helping and protecting is affiliative but also is more actively involving and influencing of patients. It connotes an active working together which is very similar to the concept of positive complementary described by Henry et al. (1986).

Saltzman, Luetgert, Roth, Creaser, and Howard (1976) contribute to an understanding of building and maintaining a positive alliance. These researchers developed a set of client and therapist dimensions that they considered important to the formation of a therapeutic alliance, and then attempted to explore the earliest indicators of alliance. These dimensions are intended to be aspects of the treatment relationship that contribute to a therapeutic process, not characteristics of the individuals involved. This study found that in the first five

sessions, patients that drop out can be distinguished from patients that remain in treatment based on the dimensions of the therapeutic alliance. The viability of the treatment relationship became evident by the third session. Therapist dimensions that contribute to the alliance and that are predictive of persistence in treatment by patients are seen as early as the first session. These dimensions are the therapist's sense of concern for the patient and sense of active participation in the patient's therapeutic exploration (involvement), the extent to which the patient relies on the therapist versus themself to solve problems (responsibility), the therapist's assessment of the extent to which the patient is able to understand problems and make progress in solving them (movement). These suggest that in the first session, therapists need to be sensitive to cues that indicate a collaborative effort being formed along these three dimensions. Particular attention should be given to whether or not the therapist feels involved with the patient and whether or not the therapist feels the patient is actively involved in actively working toward a solution. Early success in treatment was dependent on the interaction and mutual influence between the therapist and patient toward greater patient involvement, responsibility, and movement.

By the fifth session, the factors that best distinguished successful treatment were the therapist's ability to accept and respect the patient as the person he/she is (respect), the therapist's sense of being involved in a continuing relationship (continuity), and again, involvement by the patient. For patients, distinguishing factors were confidence that the therapist was both competent and committed to be of help as long as needed (security), respect, and continuity. Successful therapists were aware of and contributed to a collaborative effort to explore, understand, and solve problems. An important part of this collaborative effort was the perception by the patient and the therapist that the relationship was

ongoing for as long as needed by the patient, and the perception by the patient that the therapist was competent. Addressing early problems in the therapeutic relationship likely involves discussing any of the above mentioned areas of the alliance that are developing poorly.

In summary, Saltzman et al. (1976) found that the role of therapists was to be aware of cues of a collaborative effort being formed. Collaboration is defined as the therapist feeling his or her self being involved with the patient, which requires a low level of hostility on the part of the therapist, and the patient actively working on their problem (involvement, responsibility, and movement). According to this study, it is the work of establishing and maintaining mutual involvement that defines effective therapist functioning. While remaining involved, the therapist must maintain a respect for the patient, and contribute to a sense of continuity and security in the relationship. Consequently, dealing with variability in alliance means dealing with variations, not only in the therapist feelings about the patient, but in the collaborative effort including variations in the level of patient involvement, responsibility, and movement. Dealing with variations in the pattern of interaction between the patient and therapist is part of the therapeutic process and part of important therapist functioning. This study is important due to its attempt to specify therapist functioning that contributes to building and maintaining the alliance.

Crowder (1972) studied the frequency of countertransference behavior as it related to outcome in psychotherapy, hypothesizing that countertransference behavior is inversely related to reality oriented behavior, and inversely related to positive outcome. He used an interpersonal diagnosis schema and its components as factors to study the frequency of countertransference versus reality oriented behavior by therapists. The classes of behavior from this schema

used as factors were supportive-interpretive, support-seeking, hostile-competitive, and passive-resistant behaviors. In the study it was assumed that supportive-interpretive behavior was reality oriented and that the other three were countertransference behaviors.

This study compared successful therapies with unsuccessful ones. The findings showed a difference between successful and unsuccessful therapists, in late sessions only, in terms of the frequency of supportive-interpretive behavior. In late sessions, successful therapists were more supportive-interpretive than unsuccessful therapists. In early and middle sessions there was no difference between successful and unsuccessful therapists concerning this variable. In early sessions, successful therapists were significantly more hostile-competitive and less passive-resistant than unsuccessful therapists. In late sessions unsuccessful therapist were significantly more hostile-competitive and more passive-resistant than successful therapists. The study indicates that while both groups of therapists, successful and unsuccessful, demonstrated countertransference reactions, the successful therapists were able to resolve these feelings. Of the type of countertransference reactions, successful therapists more frequently reacted with hostile-competitive feelings than passive-resistant feelings compared to unsuccessful therapists. Submissive countertransference reactions apparently hinder treatment more than dominant countertransference reactions. The study indicates that to the degree therapists resolve their early countertransference reactions in order to assume a supportive-interpretive stance as therapy progresses, the chance of successful treatment increases as a result. Along with the findings of Saltzman et al. (1976), this study demonstrates the importance of therapists resolving problematic feelings toward patients.

Foreman and Marmar (1985) studied the therapist actions that might differentiate patients with improved alliances from those with sustained problematic alliances. The subjects of the study sample were all determined to have poor alliances initially as rated by independent judges using the Therapeutic Alliance Scale. There were three therapist actions that helped distinguish improved alliances from nonimproved alliances. First, the most consistent finding was that when therapists addressed defenses the patient used to deal with feelings toward the therapist and others, the alliance was helped. Second, when the therapist addressed the patient's tendency to self punish to relieve guilt in the presence of anger, or to relieve feelings of responsibility for another person's suffering, the alliance was helped. Third, when the therapist addressed the patient's problematic feelings in relation to the therapist, the alliance was improved. In this study, interpretive work that avoided rather than addressed a poor alliance was not ultimately successful in relation to outcome. This study indicates that therapists can effect the strength of the alliance by addressing problems in the alliance, and that this work likely should precede other interpretive work. This study is limited by its use of only six subjects. A replication of this study with a larger sample would be a valuable contribution to the literature due to its unique exploration of cases determined to have problematic alliances.

Summary

The therapeutic alliance, consisting of both patient involvement and therapist offered relationship, contributes positively to therapy outcome as measured by symptom or problem reduction, and as measured by internal change in personality functioning. The group of studies in this section reviews findings concerning both patient and therapist contribution to the therapeutic

alliance. Three studies, Strupp and Hadley (1979), Gomes-Schwartz (1978), and Kolb et al. (1985), indicated that patient involvement is more important to the alliance, and successful therapy outcome, than therapist offered relationship. Three studies, Strupp and Hadley (1979), Bottari and Rappaport (1983), and Cooley and Lajoy (1980) indicated that patient involvement is influenced by the therapist offered relationship. When patients experience therapists as accepting, understanding, caring, having genuine interest and having a positive affective condition, then therapy outcome is positively affected. Therapists, first and foremost, contribute to a helping alliance by manifesting these characteristics and by functioning in a manner that aids the patient in perceiving these characteristics.

Therapists contribute to establishing and maintaining the alliance by functioning in ways that go beyond manifesting the above stated characteristics. The findings of Saltzman et al. (1976) indicated that therapists do this by being aware of and contributing to a collaborative effort to explore, understand, and solve patient problems. This means being involved in the patient's therapeutic exploration, being aware of the patient's level of responsibility for their problems, and being aware of the patient's level of understanding of problems and movement toward solving them. Marziali (1984b) and Buckley et al. (1984) showed that contributing to the alliance involves helping patients to reach a stable identification with the therapist, and involves maintaining a positive balance in the alliance. This includes working through early relationship conflict between the patient and therapist. In order to help the alliance, Foreman and Marmar (1985) found that therapists should address defenses the patient uses to deal with feelings toward the therapist, and should address the problematic feelings patient's have in relation to the therapist. Helping the alliance also

involves being aware of and discussing multiple communications. Multiple communications are single thoughts containing more than one meaning or interpersonal message. Finally, therapists successful in establishing good alliances with patients are able to resolve problematic countertransference feelings (Crowder, 1972). This allows for establishment of a supportive and interpretive stance as therapy progresses.

In the following section the review will focus on identifying specific techniques or interventions by therapists that contribute to positive therapy outcome beyond the ways in which therapists contribute to the process of building and maintaining a therapeutic alliance.

Therapist Interventions

Therapist Characteristics and Therapist Functioning

Luborsky, McLellan, Woody, O'Brien, and Auerbach (1985) investigated four factors that might account for the variability of outcome between different therapists. The study included three distinct treatment modalities: drug treatment, cognitive behavioral therapy, and supportive expressive therapy. The four factors studied were patient qualities, therapist qualities, patient-therapist relationship qualities, and therapy qualities. The first three factors are process variables and the fourth factor measures how consistently each therapist maintains their distinct treatment modality during the course of treatment.

Three factors emerged as significant. Patient-therapist relationship qualities, defined as a warm and supportive relationship, was the most highly correlated process variable with positive outcome, when measured at seven months after treatment, on four outcome measures (range: $r = .51\text{-}.72$; $p < .01$). The therapist qualities variable was not as highly correlated with outcome, but

was highly correlated with helping alliance (r = .74). This implies that therapist qualities do not directly affect outcome as much as they influence the therapist's ability to form a helping alliance. It is the helping alliance that produces a positive influence on outcome.

The third variable, purity or quality of the particular therapy, positively correlated with seven measures of outcome (r = .49; p < .05 and range: r = .36-.50; p < .01). Purity is a measure of the extent to which the therapist exhibits exclusively the intended qualities of the designated therapy modality. This variable was independent of the other three variables being studied in its relation to outcome. In summary, this study provides evidence that therapists do, on the basis of their functioning, contribute to positive treatment outcome beyond their contribution to positive alliance.

Jones, Cummings, and Horowitz (1988) reported that effective therapists clearly use different techniques to shape and define the therapist-patient relationship or helping alliance. They measured the treatment process in this study with a Psychotherapy Process Q sort. The purpose of the Q Sort was to describe and classify the therapy process. It is comprised of three types of items: those describing patient attitude and behavior or experiences, those reflecting the therapist's actions and attitudes, and those attempting to capture the nature of the interactions in the dyad or the climate or atmosphere of the encounter. Of the 100 items, 27 were significant predictors of treatment outcome. Of these 27, 26 of the items were significant due to interaction effects between the item and the level of patient pretreatment disturbance. Only one item ("Patient achieves a new understanding or insight") predicted outcome independent of the seriousness of patient pathology (F of R2 change = 4.66, p < .05). The data suggested two different therapeutic stances for successful outcome in therapy,

one for high levels of psychopathology and another for low levels of psychopathology. These are described in the following paragraph.

The process of successful therapy with more severely disturbed patients had an external focus, one that focused away from emotional conflicts and personal meaning of experience and toward a more reality-oriented construction of the patient's problem. It involved the therapist assuming a position of being actively supportive by taking over some of the patient's decision-making functions for a time, offering recommendations and concrete advice and encouraging the patient to take specific action. Robert Wallerstein describes this process as "the evocation and the firm establishment of a positive dependent transference attachment" (Wallerstein, 1989, p. 200). This represents an anxiety suppressive stance. In contrast, the type of approach by therapists that appears beneficial to successful outcome with patients with low pretreatment disturbance is more internally focused. This approach focused on the affective responses and personal meanings associated with the patient's experiences. It also focused on the patient's conflict about feeling dependent on the therapist and efforts by the patient to transform the relationship into a more personal and intimate one. In this type of treatment the therapist can help by sometimes explaining or answering questions about the process of therapy and what is expected of the patient in treatment. The therapist stressed emotional content in order to help the patient experience affect presently. This experience is then related to long-standing and/or present relationship conflicts, including an emphasis on the nature of the interaction and interpersonal process in session with the therapist. The study recommended an active and purposeful approach by the therapist.

Horowitz, Marmar, Weiss, DeWitt, and Rosenbaum (1984) designed a study to research specific therapist actions and their effects on the outcome of treatment. The subjects were all seeking psychotherapy after the death of either a parent or a spouse. The design of the study was to compare the effect of patient pretreatment characteristics, the therapeutic alliance, and therapist actions or interventions on outcome. Patient characteristics or dispositional variables in the study were defined by the patient's motivation for dynamic psychotherapy and by the level of organization in the self-concept of the patient. Alliance variables for the study, derived from the Therapeutic Alliance Scale, were the therapist's positive contribution to the alliance, the therapist's negative contribution to the alliance, and parallel positive and negative contributions by the patient. The research showed that the only significant relationship between patient dispositional variables and outcome was that patients with higher ratings on developmental level of self-concept showed a more favorable outcome in the area of work and interpersonal functioning. Contrary to other studies, the patient's positive contribution to alliance did not correlate with positive outcome, however the patient's negative contribution affected the outcome as measured by a smaller rate of decline in symptoms ($r = -.34$; $p < .05$). The only significant relationship between therapist action or intervention and outcome, as measured by the Patterns of Individual Change Scales, was the therapist's effort to clarify the focus of treatment ($r = .31$, $p < .05$), leading the authors to conclude that a limited focus facilitates progression by countering diffusion. This finding may be a result of the specific presenting problem of all subjects in this study (a grief response due to loss of significant other).

The researchers then compared the independent variables to see if interactions between them positively affected outcome. First they evaluated the

relationship between the patient dispositional factors and therapeutic alliance in relation to outcome. The results of this analysis indicated that patients negatively contribute to alliance and outcome when there is a low level of motivation, and positively contribute to alliance and outcome when motivation is high. Furthermore, patients with low motivation for treatment still had positive outcome if their contribution to the alliance was positive. For the more highly motivated patients, higher contribution to the alliance negatively affected outcome, probably due to defensive behavior that distracts the patient from addressing their reasons for being in treatment and from addressing negative reactions to the therapist. This led Horowitz et al. (1984) to conclude that negative contribution to alliance can be used for positive outcome if worked through by motivated patients. Without the motivation, the negative contribution to alliance results in negative outcome.

Finally the authors considered the interaction of patient dispositional variables and therapist actions. The most significant finding concerns the therapist action of emphasis on differentiation of real from fantasized meaning of the stress event. This action was primarily exploratory and uncovering rather than supportive. When both patient disposition variables of motivation and developmental level were low, then therapist action negatively affected outcome. When these two variables were high, then therapist action significantly affected outcome in a positive direction. This evidence demonstrates that therapist action to help patients understand any discrepancy between their felt meaning and a reality-based meaning of the stress event was helpful with patients high on the two dispositional variables. In other findings of the study, therapist supportive actions positively contributed to outcome when interacting with patient factors of low motivation and developmental level.

In summary, the only action or intervention by therapists found by Horowitz et al. (1984) to contribute directly to positive outcome was the effort to clarify the focus of treatment. This is similar to the most significant finding of the study by Sachs (1983). In addition, patient motivation for treatment and/or positive contribution to the alliance was found to effect successful outcome. If patient motivation is present, and the patient has a higher level of psychological development, therapists can positively affect outcome by use of exploratory processes such as the differentiation between real and fantasized meanings of events. Also, therapists can affect outcome both by helping motivated patients to explore and work through weak alliance and by exploring the patient's effort to strengthen the alliance if this effort serves to detract the patient from addressing their reasons for being in therapy or any negative feelings toward the therapist. With less motivated patients, supportive interventions are more effective. This particular finding supports the finding of Jones et al. (1988).

Hoyt (1980) conducted, then replicated, Hoyt, Xenakis, Marmar, and Horowitz (1983), a study of therapist in-session functioning that correlated with good psychotherapy sessions. The Therapist Action Scale was used to rate, by independent judges, therapist behaviors. Independent judges also rated the good-poor quality of sessions. Three variables significantly correlated with good session quality in both studies, though the correlation of the third variable was low. These variables were: expression of thoughts and feelings encouraged and engaged in (1980 Study: $r = .40$; $p < .001$; and 1983 Study: $r = .47$; $p < .01$), meanings of patient's reactions discussed (1980 Study: $r = .32$; $p < .01$; and 1983 Study: $r = .35$; $p < .01$), and self concept of patient discussed (1980 Study: $r = .21$; $p < .05$; and 1983 Study: $r = .22$; $p < .05$). One other correlation, found to be

significant in the second study only, is worth mentioning. This variable, patient's responsibility discussed, correlated with good therapy sessions ($r = .41$; $p < .01$).

Sachs (1983) examined data from the same study as Strupp and Hadley (1979) and Gomes-Schwartz (1978) using the Vanderbilt Negative Indicator Scale (VNIS) to evaluate the process between patient and therapist in treatment. The subscales of the VNIS measure the negative aspects (defined in parenthesis) of the process between patient and therapist. These subscales are as follows: Patient Qualities (negative attitudes, passivity), Therapist Personal Qualities (exploitative tendencies, lack of respect), Errors in Technique (lack of structure or focus, failure to examine patient-therapist relationship), Patient-Therapist Interaction (problems in therapeutic relationship, lack of collaboration), and Global Session Ratings (destructiveness, ineffectiveness of session). The Errors in Technique subscale was most significantly related to positive overall improvement ($r = -.56$; $p < .01$), followed by Global Session Ratings ($r = -.52$; $p < .05$), and then by Patient-Therapist Interaction ($r = -.49$; $p < .05$). The negative correlations represent an inverse relationship between the VNIS ratings and positive therapeutic outcome. The study demonstrates a relationship between poor therapist in-session functioning and negative therapeutic outcome. It defines therapist functioning as lacking quality if structure and focus are not provided for the session, if the patient-therapist interaction and problems in the relationship are not examined, if collaboration is lacking, and if interventions are poorly timed or destructive.

Rounsaville, Chevron, and Prusoff (1987), as in the studies by Strupp and Hadley (1979), Windholz and Silberschatz (1988), and Gomes-Schwartz (1978), used the Vanderbilt Psychotherapy Process Scale as the tool for measuring process variables. In this case the seven factors derived from the scale were the

variables studied. These factors were: Patient Participation, Patient Exploration, Patient Hostility, Patient Psychic Distress, Therapist Exploration, Therapist Warmth and Friendliness, and Negative Therapist Attitude. Rounsaville et al. found that therapist behaviors and characteristics were better predictors of outcome than patient variables, in contrast with Gomes-Schwartz (1978). Therapist Exploration correlated with change in patient level of depression and with overall change ($r = .39$; $p < .05$ and $r = .50$; $p < .01$), as rated by patients. Therapist Warmth and Friendliness correlated with positive change in social functioning and with overall change ($r = .40$; $p < .05$ and $r = .60$; $p < .01$), as rated by patients. One explanation offered by Rounsaville et al. (1987) for the difference between this study and Gomes-Schwartz (1978) is that the therapists in this study were trained in a specific therapeutic approach such that their performance was more standardized. By reducing variation in technique and strategy, the condition and relationship offered by the therapist may have had a more substantial effect on outcome. The findings also indicated that higher therapist skills, as rated by therapist supervisors and therapist self-ratings, were dependent on the interaction between patient participation and exploration, and the therapist variables of exploration, warmth, and lower negative attitude. While therapists may positively affect patient outcome, patients that are involved seem to potentiate a higher level of therapist competence and skill in session. The direction of this influence, as in the study by Kolb et al. (1985), is again uncertain. A strength of this study is that therapist functioning was evaluated by an independent source, as well as by the therapists, and that this evaluation correlated with patient rated positive outcome.

Bachelor (1991) conducted a similar study in which she used the Vanderbilt Psychotherapy Process Scale and two other therapy process scales,

the PENN Helping Alliance Method and the Therapeutic Alliance Rating System to measure the process of therapy and to identify variables that contribute to positive outcome. Sessions and outcome were measured from three perspectives: patient, therapist, and independent judges. From the perspective of patients, the variables strongest in predicting positive outcome were therapist's warmth, friendliness, and caring; and emotional involvement or support; accounting for 49% of the variance on two patient rated outcome measures. Second, patients who perceived therapist as attempting to explore underlying dynamics of patient's problems, and therapist directiveness accounted for 48% of the variance on patient rated outcome measures. This again indicates the importance to the alliance and outcome of nonspecific variables but also suggests the importance of two specific areas of therapist functioning. From the therapist's perspective, the patient's active participation in the therapeutic process emerged as the most consistent variable contributing to positive outcome, accounting for 13% to 21% of the variance among outcome ratings. In addition, therapist exploratory interventions again emerged as a significant contributor to positive outcome, predicting 24% to 35% of supervisor rated improvement as assessed on several outcome measures.

Bachelor (1991) further establishes that both patients and therapists contribute to building a therapeutic alliance, and that the alliance is related to positive outcome. The alliance depends on therapist characteristics, and emotional involvement and support. It also depends on active participation by patients. It is not as clear that patient contribution is more significant than therapist contribution as Gomes-Schwartz (1978) suggested. Again, exploratory processes initiated by therapists positively contributed to outcome. While this study included three rater perspectives, each perspective points to different

variables as significant contributors to positive outcome. This raises the question of distortion of the findings due to rater perspective. Bachelor (1991) and Rounsaville et al. (1987) both are important for their findings of patient ratings of therapist functioning as correlated with patient rated positive outcome.

Schauble and Pierce (1974) found that therapists of successful patients functioned significantly higher on the facilitative dimensions of empathy, positive regard, genuineness and concreteness. This study provides a link between the non-specific relationship variables and one variable that indicated something about specific therapist intervention. That variable was concreteness. In this study, patients who were successful on the basis of change scores on the MMPI Profile rated therapists as functioning significantly higher on these dimensions and consistently so throughout therapy. The study indicates that successful patients increase throughout treatment on dimensions of internalization vs. externalization in interpersonal process, owning of feelings in interpersonal processes, commitment to change in interpersonal processes, differentiation of stimuli in interpersonal processes, and patient self exploration. Schauble found that therapist concreteness during the session contributed to positive change scores on patient MMPI profiles. Concreteness in this study refers to the therapist's attention and comment on concrete in-session behaviors of patients. This concrete style pertains to therapist activity to aid patients in behaving in therapy in a way that is productive toward positive changes. The implication is that operationalizing and emphasizing positive patient behaviors gives the therapist a framework within which to judge patient progress and suggests what concrete behaviors need to be attended to if the patient is to progress. Modeling and reinforcement effects were used in this study to focus on concrete behaviors for each of the five patient dimensions being measured. For

example, concreteness might involve helping patients to move from dealing with relationship problems as if the problem was entirely external to oneself and beyond one's control, to dealing with the problems by discovering one's own feelings, thoughts, and behaviors and how these contribute to the problem. Likewise it might involve helping patients with the process of self exploration. In summary, concreteness by therapists that focuses on patient in-session behavior facilitates change.

The studies from this subsection of Therapist Interventions give information both on therapist characteristics and therapist in-session functioning. As was discussed earlier in this review, patient perception of therapist characteristics is important to establishing a therapeutic alliance. Five studies in this section help to clarify which characteristics are important for successful in-session functioning by therapists. Characteristics that emerged as significant to positive outcome were: warmth, friendliness, caring, empathy, positive regard, genuineness, acceptance, and understanding. These characteristics are consistent with the findings of studies in the first section of this review, and those identified by the research prior to 1971 and reported by Truax et al. (1966) and Frank (1974). Luborsky et al. (1985) found that therapist characteristics have greater positive impact on therapeutic alliance than they do on outcome which supports conclusions from the earlier section of this review. Therapist characteristics positively affect therapy outcome by contributing to the therapeutic alliance. Patient-therapist relationship characteristics affect outcome also. These characteristics included emotional involvement, helping and protecting, and support.

Three principles of overall approach emerge from these studies. First the purity of therapy, that is consistency in following one therapy approach,

increases the quality of treatment as evidenced by its positive affect on outcome. Second, patients with more severely disturbed levels of psychological functioning respond better to a supportive, anxiety suppressive, approach by therapists. Being supportive involves an active stance and includes the relationship characteristics mentioned in the above paragraph. The third principle involves an approach applicable to patients with lower pre-treatment levels of psychological disturbance. This approach is more internally focused and exploratory. More information concerning interventions within these latter two approaches will be discussed in the following paragraphs.

These studies offer information on therapist interventions that positively affect therapy outcome. Three studies indicate that it is important to provide structure and focus for treatment, particularly by initially making an effort to clarify the goals of treatment. Clarifying also involves discussing the means, or process, by which the goals will be approached during treatment.

Three studies discuss more specifically what it means to be supportive. First, therapists are supportive by being directive, by engaging patients to take action, and by making recommendations and encouraging specific steps toward solving problems. This involves a collaborative effort where the patient responds in complimentary fashion to the therapist's evoking and helping style. It focuses away from emotional conflicts and personal meanings of experiences, and focuses toward reality oriented problem solving. Being supportive also involves therapists giving attention to concrete, in-session behavior by patients that leads to positive therapy outcome.

Other studies discuss aspects of an internal or exploratory focus in pschotherapy. Therapists assist patients by helping them to explore their feelings and the underlying dynamics of their problems. Involved is helping patients to

experience affect presently and exploring the meaning of their reactions to experiences. Therapists also assist patients by focusing on patient in-session behavior that has been shown to lead to positive change. This behavior includes patients being able to distinguish between different stimuli and different feelings; taking ownership for thoughts, feelings, and behaviors; and changing problem patterns in their interpersonal relationships. As was seen when discussing ways therapists aid in establishing and maintaining the alliance, exploration also involves helping patients address weak alliances. The weak alliance may be due to problematic feelings toward the therapist, or due to an overemphasis on the therapeutic relationship by patients. The latter is a problem if it serves to help patients avoid their negative feelings, or to avoid the reasons that they are in treatment.

Verbal Response Behavior

Elliott, Barker, Caskey, and Pistrang (1982) studied the helpfulness of therapist verbal response modes on outcome. Conceptually, response modes were distinguished by two aspects: the intention of the therapist and the behavior or verbal form used to communicate the response. The response mode was rated three ways: by trained raters of the therapist's behavior, by patient's ratings of the therapist's intentions, and by therapist's ratings of their own intentions. Ratings of therapist verbal response behaviors were on six dimensions: Advisement, Interpretations, Questions, Reassurance, Reflection, and Self-disclosure. The intentions of the therapist as perceived by the patient, and therapist perceived intentions of themselves, were rated in terms of what the therapist was intending or trying to do with the verbal response. The verbal responses were analyzed for their possible correlation with ratings of helpfulness. The ratings of helpfulness were obtained by asking both patients

and therapists to rate the helpfulness of the behavioral aspect of the verbal response. The relationship between verbal response behaviors and helpfulness ratings was significant but small. More importantly, there was a fairly strong correlation between observer perspective and ratings of helpfulness. Helpfulness was associated with how the observer perceived the response rather than the verbal response itself, that is, perceived intention was more important than verbal response mode. Even though correlations were low for all verbal response modes, the results indicated that interpretation was the most helpful type of therapist intervention or verbal response mode correlating with helpfulness ratings by patients and therapists (range r = .15-.25; p < .05), advisement was the second highest correlation with helpfulness ratings (range r = .19-.20; p < .05), and questions was the least helpful.

Hill et al. (1988) conducted a similar study to see if verbal response modes were correlated with helpfulness. They also analyzed verbal response modes by comparing them to therapist intentions and patient state to see which of the these three variables affected helpfulness more. Additionally, helpfulness was measured and analyzed in relation to pretreatment symptomatology, immediate outcome in sessions, session outcomes, and treatment outcomes. As in the previous study, response modes had a small but significant effect on outcome when considered alone. However when considered along with the other two process variables, therapist intentions and patient state, the unique contribution of response modes became insignificant. Again, this study confirmed the findings of Elliott et al. (1982) that the effect of response modes was due to the underlying intentions of the therapist rather than to the response mode itself. Patient experiencing, an aspect of patient state at the point of the verbal response, also accounted for more variance than did response modes when measured as a

main effect and in interaction with intentions of the therapist. At low levels of patient experiencing, both therapists and patients rated as most helpful those interventions that were aimed at exploring feelings and behaviors of patients. At high levels of patient experiencing, almost all therapist interventions were helpful indicating that patients who are at a high point of experiencing utilize differing therapist interventions to their advantage. Apparently the type of intervention is more critical for patients at low levels of experiencing.

Two conclusions can be drawn from these studies on verbal response behavior. First, the perceived intentions of the therapist are more important to therapist helpfulness than particular verbal response modes. This again emphasizes the importance of qualitative aspects in the therapy process that are likely affected by non-specific relationship factors. Second, the patient's state, that is their current level of experiencing, affects the helpfulness of therapist verbal interventions. Specific types of interventions are more critical with patients who are in a state of low experiencing. These appear to be interventions that help patients to better or more fully explore their feelings and behaviors. These studies made it clear that interventions are effective when closely matched to patient's individual differences rather than a particular type of intervention being distinguishable as more effective than other interventions.

Patient perception of a therapist's effort to be helpful was also found to be important in the study by Free, Green, Grace, Chernus, and Whitman (1985). The purpose of the study was to understand the importance of empathy in Brief Focal Dynamic Therapy. Empathic responding to patients by therapists was rated from the perspective of patients, therapists, and supervisors. Only patient ratings of therapist empathy correlated significantly with any of the five outcome measures used. Patient ratings of therapist empathy correlated with

improvement, a decrease, on the hostility subscale of the SCL-90-R (r = -.35; p < .05). Patient ratings of therapist empathy also correlated with improvement on the quality of interpersonal relationship subscale of the Health-Sickness Rating Scale (r = -.28; p < .05). When patients feel understood as a result of empathic statements by therapists, it is helpful to patients. This happens regardless of the accuracy of the empathic statements as rated by therapists and supervisors.

Interpretations

Crits-Christoph, Cooper, and Luborsky (1988) found that the variable helping alliance was positively related to two measures of outcome, rated benefits and residual gain (r = .31; p < .05 and r = .36; p < .05), and was independent of the variables accuracy of therapist interpretations and therapist errors in technique. Accuracy of interpretations also showed a moderately strong correlation with positive outcome and was also independent from the other two variables. Interpretations were made in response to patient's verbalizations as these verbalizations related to the patient's central relationship patterns. The patterns were divided into three components: the patient's main wishes, needs, or intentions toward the other person in the narrative; the responses of the other person; and the responses of the patient to the other person.

Accuracy of interpretations was determined by comparing the core conflictual relationship theme, as manifested in the session by one of the three components, with the therapist interpretations. Accuracy was based on the congruence between patient content and therapist interpretations. Among the three types of interpretations, the best predictor of outcome was accuracy of interpretation concerning the patient's wish plus the response of the other person

in the narrative . This factor was correlated with positive rated benefits and positive residual gain scores ($r = .38$; $p < .05$ and $r = .44$; $p < .01$). It appears that correctly addressing the patient's stereotypical patterns of needs and wishes, followed by addressing the responses of others, whether compatible with the wish or not, is an effective strategy. However, limiting the interpretation to only the patient's usual responses (typical feeling states) and wishes in interpersonal situations is not by itself a productive technique. These findings indicate that therapists can affect outcome by a specific type of interpretive intervention. Therapist errors in technique were not found to negatively effect outcome as they were found to do in the study by Sachs (1983).

Luborsky, Bachrach, Graff, Pulver, and Christoph (1979) studied the preconditions and consequences of transference interpretations in three different analytic therapies. The assumption in this study was that the immediate instigator of the timing of therapist's interpretations was to be found in the material immediately before the interpretation, and that some of the consequences of the intervention could then be found in the material immediately after the interpretation. Clinical raters evaluated units of speech from verbatim transcripts within the following parameters: 250 words of patient speech before a transference interpretation, the transference interpretation, and 250 patient words after the transference interpretation. These units of speech were evaluated using nine variables considered central to the psychoanalytic process. The nine variables evaluated were: resistance, involvement with the therapist, affect, understanding and insight, transference, positive transference, manifest positive transference, negative transference, and manifest negative transference. This was done for 16 transference interpretations identified by

clinical raters from the transcripts. In this study, interpretation was defined by Luborsky et al. (1979) as:

> a reference by the therapist to unconscious material—defensive operations, motives, and warded-off instinctual derivatives—and to the hidden meanings of the patient's behavior patterns and their interconnections. In contrast to clarification, interpretation goes beyond the clinical data and tries to explain to the patient the unconscious processes assumed to influence manifest behavior. (p. 393)

When the interventions were scored as 4 or higher (on a 5 point scale) for both interpretation and reference to the therapist, they were considered acceptable as transference interpretations. The results demonstrated a consistency in response to the transference interpretations for each patient across the course of their therapy, and a corollary between the amount of immediate positive or negative response to interpretations and the ultimate response to the treatment. A negative immediate response to interpretations tended to remain consistent throughout treatment and led to a negative treatment outcome. The reverse was also true. The patient with a negative treatment outcome (patient A) had a non-significant response on all variables to interpretations other than the immediate increase in resistance. For patient B, two variables significantly increased after interpretations. The first was involvement and the second was transference. Unlike patient A, resistance began to fall off gradually with each interpretation. For patient C, interpretations had an even greater effect. All variables but resistance became significantly higher after interpretations; especially involvement, understanding, and transference. This patient's feelings intensified and she became more involved with the therapist as a transference object. It was patient C that had the most positive outcome in treatment with patient B having a moderately positive outcome. In this study, there were

variations in the effect transference interpretations had on patients even when controlling for the technical quality of the interpretation. This would imply that the transference interpretation was received differently and had different effects on the patients. The study suggested that the response of a patient to transference interpretations, whether positive or negative, may be an indicator of treatment outcome: positive response indicating a positive outcome and a negative response indicating a negative outcome.

McCullough et al. (1991) had similar findings in a study which hypothesized that the frequency of occurrence of patient affective response in the three minutes following therapist interventions is positively correlated with outcome; and the frequency of patient defensive responding in the three minutes following therapist interventions is negatively correlated with outcome. Several types of interventions were identified along with the patient response to the intervention. These responses were then rated by clinical judges. The interventions identified were clarification, patient-therapist relationship interpretation, and other relationship interpretation. Defensive responses to therapist interventions were all correlated negatively with outcome. However, only the category that combined into one score all three types of interventions, followed by defensive responses, was significantly correlated with negative outcome ($r = -.50$; $p < .05$) as measured by the Composite Outcome Score. Conversely, patient affective responses to therapist interventions was positively correlated with the composite outcome score used. Both patient-therapist interpretations ($r = .60$; $p < .05$) and the combined interventions score ($r = .51$; $p < .05$), when followed by affective responses, significantly correlated with positive Composite Outcome Scores. Clarification, according to this study, was not correlated with positive outcome, even if followed by an affective response.

Similar to Luborsky et al. (1979), the patient's early and predominant response to interventions is an indicator of outcome in both positive and negative directions. For example, predominantly positive responses to interventions are an indicator of positive therapy outcome. The reverse is also true. Moreover, sixty-six percent of the study's variance in outcome was accounted for by two specific interactional sequences: patient-therapist interpretation followed by affect correlated with positive outcome, and all interventions followed by defensiveness correlated with negative outcome.

Marziali (1984a) studied the relationship between specific types of interpretations and outcome. The following three interpretations were identified as variables: explanatory statements with reference to a parent or sibling, statements with reference to other persons in the patient's social orbit, and statements with reference to the therapist or therapy. Outcome measures were in two categories: global and symptom improvement, and psychodynamic change. The five scales developed to measure psychodynamic change were: friendship, intimacy, capacity to use support, self-esteem, and assertiveness. The ratings on these scales represented possible psychodynamic change at three months after termination. In the analysis, no correlation was found between the specified interpretations and global improvement or symptom improvement. An effect of the three types of interpretations on the dynamic scales was observed. Interpretations involving the therapist and the patient's parent or sibling significantly affected the patient's intimacy ($r = .33$; $p < .05$) and capacity to use support ($r = .55$; $p < .05$) scales as well as the dynamic total score ($r = .57$; $p < .01$) (a summary of all five scales). Interpretations involving the therapist and other people in the patient's social orbit affected the patient's capacity to use support scale only ($r = .33$; $p < .05$). Interpretations involving the therapist, the patient's

parent/sibling, and others in the patient's social orbit affected the patient's friendship ($r = .40$; $p < .05$), self esteem ($r = .45$; $p < .05$), assertiveness ($r = .40$; $p < .05$), and capacity to use support scales ($r = .53$; $p < .05$) as well as the dynamic total score ($r = .57$; $p < .01$). The authors tested the interpretation variables and outcome measures to ascertain independence of or overlap between the measures. Both the therapist/parent and the therapist/parent/other interpretations were predictive of positive outcome as measured by the capacity to use support subscale, affecting 23% and 22% of the variance. The therapist/parent/other interpretation was predictive of outcome on the dynamic total score which affected 15% of the variance. This means that these two variables can be considered as separate and helpful types of interventions.

One of the troubling implications of these findings is the lack of correlation between the interpretive variables that helped the patient's interpersonal functioning, and the more easily identified reasons that the patients were in treatment, that is for global and symptom improvement. Given that this study was based on short-term (20 sessions) treatment, one explanation could be that improved psychodynamic and interpersonal functioning would eventually correlate with symptom reduction should treatment be extended further or be given more time for the psychodynamic changes to contribute to symptom change. Another possibility is that this type of therapist functioning contributes to a positive alliance and that the process of the alliance affects symptom reduction. In this study, it would have been helpful if the researchers had done an analysis to see if improvement on any of the dynamic outcome scales were correlated with improvement on any of the three outcome measures used. This would help further assess whether or not the interpretations being studied were

related to positive therapy outcome. In this study, while the patients may have shown symptom and global improvement, the interpretive variables measured in the studied were not correlated with this type of improvement.

Piper, Debbane, Bienvenu, Carufel, and Garant (1986) studied the effect on outcome of interpretations concerning patient relationships with particular persons (objects), including interpretations that link the patient's relationship with objects and the patient-therapist relationship. First, interpretations had to be identified, then interpretations containing particular objects were rated. To accomplish this, independent raters used audio material and an instrument called the Therapist Intervention Rating System to rate the object interpretations of 21 short-term individual therapy patients. Examples of interpretations concerning object relations were attempts to explore the patient's conflicts as traced through his/her current relationships outside therapy, his/her immediate relationship with the therapist, and the patient's past (early parental) relationships. The study found no significant relationship between single object interpretations and outcome or between linking interpretations and outcome. Piper et al. (1986) offer the following possible reasons for the lack of significant findings: (1) the impact of object focus on outcome is weak relative to the strength of other important variables, such as patient characteristics and receptivity, therapist characteristics and style, and the helping alliance, and (2) aspects of interpretations other than object focus, such as those that deal with the dynamic components of wishes, anxiety, and defenses, probably have a more important influence. In addition, the reason for the lack of positive findings could be accounted for by factors of correspondence and concentration explored in the study that follows.

Piper, Joyce, McCallum, and Azim (1993) studied the concentration and correspondence of transference interpretations in treatment, their effect on the therapeutic alliance, and their effect on outcome. Concentration refers to frequency of transference interpretations and correspondence means the accuracy or correctness between the therapist's formulation of the patient's repetitive conflicts and the interpretation content. Two additional types of variables were measured. The first was a patient characteristic labeled quality of object relations, and the second was the therapeutic alliance. Piper et al. (1993) distinguishes between classic interpretations, defined as the therapist's reference to the components of intrapsychic conflict, and transference interpretations which involve linking the patient with people and discussing their interpersonal dynamic. Analysis was done to find any correlations between concentration of transference interpretations and therapeutic alliance, and between concentration and outcome. For patients rated with high quality of object relations (QOR), concentration had a significant inverse relationship with positive alliance and all three outcome variables. Higher concentration weakened alliance and subsequently negatively affected outcome. There was no significant effect with low QOR patients. Further analysis indicated that effective responses to transference interpretations occurred for 50% or more of patients when the concentration was equal to or less than one per every 12 interventions. These results have also been reported in Piper, Azim, Joyce, and McCallum (1991).

The analysis of correspondence of transference interpretations indicated a significant and inversely related correlation between transference interpretation and therapeutic alliance for low QOR patients. Apparently, high correspondence in transference interpretations was hard to tolerate by low QOR patients. It could be that low QOR patients are in need of finding and forming a gratifying

relationship before they can explore their patterns of nongratifying relationships, that is negative transference patterns, in therapy. These findings support Jones et al. (1988) and Horowitz et al. (1984) in their conclusions that a supportive approach is successful with patients with more severely disturbed levels of psychological and interpersonal functioning. Further analysis did indicate a positive effect for high QOR patients when there is low concentration and high correspondence of transference interpretations. Accuracy and correctness, which defines correspondence, was found to be essential to the effectiveness of interpretations for this group. These patients were better able to tolerate dealing with negative aspects of the therapeutic relationship when these were interpreted. Exploring these processes was effective with patients who had healthier levels of pre-therapy functioning in their quality of object relationships.

Findings from the study by Coady (1991b) provide further understanding about concentration and correspondence. This study considered affiliative and disaffiliative social behavior and its association to outcome, to therapist verbal response modes, to the focus on patient affect. Therapists of patients with poor therapy outcome exhibited significantly more disaffiliative than affiliative behavior. In addition, therapists of the poor outcome group of patients had a significantly higher frequency of disaffiliative interpretive interventions. These types of interpretive interventions were defined in two ways. First were interventions that were intended to expand patient understanding. Second were interventions that present to patients intrapersonal discrepancies (confrontation). These general interpretations were found by Coady (1991b) to be more frequently conveyed in a disaffiliative manner than other types of interventions. Disaffiliation is similar to low level of correspondence.

This study by Coady (1991b) found that the percentage of disaffiliative responses that focused on the therapist-patient relationship was more than twice the percentage of disaffiliative responses that did not focus on the therapist-patient relationship. Both general interpretations and interpretations that focus on the transference relationship are prone to low levels of correspondence with patient state and experiencing. Coady (1991b) suggests that a small number of disaffiliative interpretive intervention may have an adverse effect on patients. Interpretations, particularly transference interpretations, require particular attention to timing, accuracy, and sensitivity in their use.

Silberschatz, Fretter, and Curtis (1986) discussed a common methodological problem in studies of therapist in-session functioning: researchers often fail to assess the goodness of fit between the therapist's interventions and the patient's particular problems and treatment goals. This study, like Hill et al. (1988), Luborsky et al. (1979), McCullough et al. (1991), and Piper et al. (1993) considers the immediate effect of therapist interventions on patients. According to the authors, a procedure for evaluating the suitability of therapist behavior in relation to the particular problems of the patient is needed. This involves being able to identify the patient's problems, needs, and goals and then being able to determine if a given intervention appropriately addresses them. The study hypothesized that interpretations which are suitable to the patient's goals will be more predictive of patient progress than the specific type of interpretation. This single case study design used each interpretive event to measure immediate impact on the patient's level of experiencing. Thus within each case there are multiple events from which to measure immediate impact of the therapist's interventions, in this case interpretations, on patients.

The study defined interpretation as any intervention in which the therapist suggested or implied an emotional content of the patient over and above what the patient had already said. This might include intrapsychic or non-transference interpretations, or transference interpretations. Intrapsychic or non-transference interpretations included the patient's feelings about people other than the therapist. Transference interpretations were defined as any interpretation directed toward the patient's feelings about the therapist or the therapy. For the study clinical judges categorized all therapist interventions from verbatim transcripts. Interpretations were categorized as either nontransference or transference interpretations. Next, a formulation of the patient's plan—that is, their problems, needs, and goals—was developed by a team of clinicians based on the following components: patient's goals for therapy, inner obstacles preventing the attainment of goals, the means by which the patient would test the therapist to disconfirm their pathogenic beliefs, and the insights that would be helpful to the patient. The third component of this plan formulation is based on control mastery theory developed by Weiss and Sampson (1986) and the Mount Zion Psychotherapy Research Group which contends that patients try to disconfirm pathogenic beliefs through testing these beliefs in the relationship with the therapist. It is these pathogenic beliefs that create the obstacles to attaining goals. Finally, the Plan Compatibility of Interventions Scale was used by clinical judges to evaluate each interpretation according to its compatibility with the plan formulation. The outcome variable in the study was the response of the patient to the interpretations as measured by the Experiencing Scale (EXP) which evaluates pre-interpretation and post-interpretation segments of the patient's speech. The scale taps such constructs as insight, patient involvement, lack of resistance, and productive free association.

An analysis was done to see if nontransference or transference interpretations, independent of their compatibility with the patient's plan, affected patient's residual gain scores on the EXP Scale. In two of the three cases studied, there was no significant difference between transference and nontransference interpretations on the EXP scores. In one case, nontransference interpretations were positively associated with patient experiencing. The significance of these results is that transference interpretations, without consideration for their compatibility with a patients plan, did not further immediate patient progress on the EXP Scale more than nontransference interpretations. To test the hypothesis that suitability of interpretations were positively associated with a deepening in the patient's immediate progress, analysis was done to see if plan compatible interventions were correlated with gain scores on the EXP Scale. Across all three cases, interpretations judged to be plan compatible tended to be followed by an increase in the patient's EXP score. Interpretations judged to be plan-incompatible tended to be followed by a decrease in the patient's EXP score. Additionally, in comparing plan compatible nontransference and transference interpretations, results showed that suitable transference interpretations did not further patient experiencing more than suitable nontransference interpretations. This lends support to the hypothesis that it is not the type of interpretation that is effective but the suitability of the interpretation to the patient's plan.

The limited number of subjects in this study by Silberschatz et al. (1986) was due to the intensive line by line analysis of verbatim transcripts used to measure the variables. The limited number of cases studied raises questions about the ability to generalize the findings. The study also failed to address the relationship of plan compatible interpretations to outcome. It would have been

helpful if there had been data to establish that patient experiencing, as measured by the EXP Scale, was related to positive therapy outcome. The plan compatible interpretations could then be linked to positive outcome.

Silberschatz (1986) studied a central hypothesis proposed by Weiss and Sampson in the formulation of control mastery theory. As mentioned in the previous review, Weiss and Sampson believe "that the patient works unconsciously throughout treatment to disconfirm pathogenic beliefs by testing them in relation to the therapist" (p. 256). The goal of the patient is to overcome the dangers or fears associated with the pathogenic beliefs. The goal of this study was to examine the immediate effects of the therapist's response to the tests of the patient. The effect on the patient due to the therapist's response was measured in terms of change in level of anxiety, change in level of relaxation, change in the direction of positive attitude toward the therapist, and change in the direction of being more involved in the therapeutic work as evidenced by boldness in solving problems.

To conduct this research, the methodology required three steps: 1) the reliable identification of the patient's key tests; 2) reliable judgments of whether or not the therapist's responses to these tests would be perceived by the patient as disconfirming the belief the patient was testing; and 3) independent and reliable measurements of the patient's behavior and affects. These assessments were done just before and just after the tests in order to determine whether the patient changed in the predicted direction for each of the measurements listed in the previous paragraph. One set of independent raters was used to identify patient tests of pathogenic beliefs via developing a plan formulation from verbatim transcripts of 100 treatment hours. A second set of independent raters judged how well the therapist responded to the tests in terms of confirming or

disconfirming the pathogenic belief embedded in the tests. The patient's behavior and affect were measured, again from the verbal content in the transcript, immediately before the tests and the therapists response, and immediately after. The measures used were scored by a third set of independent raters.

The measures used were the Experiencing Scale which is thought to tap such constructs as insight, lack of resistance, and high quality free association; the Boldness Rating Scale which measures the extent to which the patient boldly approaches issues or retreats from them; the Relaxation Scale which measures the degree of freedom and relaxation in the session; and a measure to evaluate the presence of the affects of love, satisfaction, anxiety, and fear. The results showed a significant correlation between the degree to which the therapist passed the patient's test and six of the seven areas being measured for change in the patient, all in the direction predicted by the hypothesis. "How well the therapist passed the test correlated significantly with changes in the patient's level of experiencing, boldness, relaxation, and love. There was a significant negative correlation between how well the therapist passed the test and changes in the patient's level of fear and anxiety" (p. 256). The study shows that there are demonstrable immediate effects of a passed test, including the patient becoming less anxious, more friendly to the therapist, more productive in the therapeutic work, and more relaxed.

Silberschatz and Curtis (1993) again used the events paradigm research strategy, asking which therapist interventions in which momentary context will lead to which immediate and subsequent impacts. The study was limited to two subjects but multiple events were measured in each case. A plan formulation was established for each patient based on the components mentioned in the

previous study. A patient test scale was used to measure points in therapy sessions where clinical judges believed that the patient was testing their pathogenic beliefs with the therapist. According to control-mastery theory on which the hypothesis of the study is based, an effort to disconfirm pathogenic beliefs is a naturally evolving process in the psychotherapy treatment. The same judges rated the degree to which the therapist behavior confirmed or disconfirmed the patient's central pathogenic beliefs. Again, the Patient Experiencing Scale was used to measure the impact on the patient of the therapist behavior in response to the patient's test. Two additional scales were used to measure the patient's response: the Boldness Scale and the Relaxation Scale. The Boldness Scale measures the patient's ability to confront nontrivial material. The Relaxation Scale measures the patient's "psychic state of freedom, relaxation, and comfort versus that of anxiety, driveness, and beleaguerment" (Silberschatz and Curtis, 1993, p. 406).

In the analysis, there was a correlation between the therapist passing the patient's tests, and an increase in the level of experiencing for both patients ($r = .35$; $p < .01$ and $r = .40$; $p < .01$). The failure to pass patient tests was correlated with decreased levels of patient experiencing. In one of the cases, passing the patient tests was correlated with increased scores on the Boldness ($r = .45$; $p < .01$) and Relaxation ($r = .37$; $p < .01$) Scales. This was not true for the other case. This study indicates that patients do have immediate responses to therapist interventions and that these responses are determined to a significant degree by the suitability of the therapist behavior to the particular problems and needs of the patient. Still, there was no relationship established between increased experiencing and successful outcome in treatment. The study makes the assumption that increased experiencing, boldness, and relaxation lead to

positive outcome in treatment. As mentioned before, it would be helpful if the researchers could explore this connection in subsequent research studies.

Caston, Goldman, and McClure (1986) designed a study to test the immediate effects of the therapist's verbalized interventions on the patient. According to general psychoanalytic concepts, an effect is positive "if the patient's associations progress in the direction of lessened defensiveness" (p. 277). Two hypotheses were tested. The first is a case specific hypothesis derived from control mastery theory. According to this hypothesis, the immediate effect of an intervention depends on its compatibility with the patient's unconscious plan. "The plan concept assumes that if a conviction about an unconscious or conscious danger can be overcome, the patient may be free to pursue a goal that was previously inhibited by that conviction" (p. 277). The second hypothesis states that immediate effects depend on the interpretiveness of the therapist's interventions. Interventions are considered interpretive generally to the extent that they "elucidate unconscious associative or causal linkages, name warded-off states or relations, or provide a preparatory focus on material proximal to that being warded off" (p. 280). Examples given by the author are inferences bound both to contents of the patient context and to general conventions regarding defensive behaviors, developmental sequence, and Oedipal/pre-oedipal dynamics. Interpretiveness facilitates a lessening of warded off processes in the patient. The first hypothesis based the effectiveness of interpretiveness on the use of plan compatible interpretations. The second hypothesis suggested multiple factors and themes as contributing to immediate effects. The purpose of the study was to determine if the two hypotheses were separate or, if not, to clarify how they overlap.

The study tested the effect of each type of intervention along two dimensions: boldness and insight. The scales used to measure these dimensions are identical to the ones in the previous study. Independent raters were used to identify and evaluate interpretations, and to evaluate the two patient dimensions before and after the interpretation. Patient verbalizations were rated from verbatim transcripts before the interpretation by the therapist and after the interpretation. The results supported the second hypothesis, the analytic interpretiveness hypothesis, but did not support the plan compatibility hypothesis. The study found a correlation between the patient's initial levels of both boldness and insight preceding the intervention and the post-intervention levels. In other words, the degree to which these conditions already existed heightened the possibility that the interpretation affected the patient along these dimensions. To test the degree of contribution coming from the intervention alone, the portion of the variance in postintervention levels of boldness and insight affected by preintervention levels was statistically removed. After accounting for pre-existing levels, there was still a significant correlation between analytic interpretiveness and change on the two dimensions measured. No correlation between plan compatible interpretations and change on these two measures was found.

The authors suggested reasons why this study did not indicate a significant correlation between plan compatible interpretations and the two dimensions measured, as was found in the preceding study by Silberschatz (1986). The authors postulated that plan compatible interpretations are most effective on patient responses when the degree of transference and testing in the interaction is highest. To test this, they further narrowed the sample of 81 interactions to the third containing the highest test power and then further

narrowed the sample to include interactions that were also "transference-referent." When this more limited sample was examined for high levels of both patient testing and patient transference with the therapist, a significant correlation was found between plan compatible interpretations and increases in patient boldness and insight. Plan compatibility is predictive of immediate positive effects, not across all interventions, but at least for those that take place during heightened therapist-patient interactions. Analytic interpretiveness is significant in its prediction of immediate effects across a broader sample of interactions. It does so independently of the planfulness dimension.

Several observations concerning the use of interpretations in treatment can be drawn from the studies in this subsection. First, effective interpretations need to be congruent with patient experiencing whether this involves intrapsychic content or transference content. When congruent interpretations are provided, intrapsychic and interpersonal aspects of functioning such as experiencing, relaxation, self-esteem, boldness, assertiveness, friendship, and capacity to use support improve. Transference interpretations can be focused on typical relationship patterns of the patient as they emerge in the treatment relationship and can be based on the patient's pathogenic beliefs about how the therapist will react to the patient. Generally a patient's initial positive or negative response to interpretations, particularly transference interpretations, is predictive of positive or negative treatment outcome. Related to this are the findings from the section on the therapist characteristics and functioning which indicate that interpretiveness is most effective when patients are higher in their level of motivation and psychological functioning. Finally, there is indication that interpretations, particularly transference interpretations, are most effective when

used in low frequency and in ways that are closely corresponding to the patient's present state of experiencing.

Summary

Several things can be concluded about the effectiveness of therapist interventions. First, effective interventions take place in the context of a collaborative effort by patient and therapist to work toward change for the patient via establishing a positive working alliance. This collaborative effort is the crux of the interpersonal process that leads to a strong therapeutic alliance. Patient involvement and contribution as well as therapist offered relationship are essential variables in collaboratively working toward the patient's goals in therapy. The patient's perception of therapist involvement and the impact to the patient of the therapist offered relationship are crucial to building a positive alliance. It is important for patients to perceive the therapist as having a positive affective state and style of relating. A positive style of relating is present when the therapist is being empathic with patients which leads to greater understanding, therapist genuineness, and unconditional acceptance of patients. Therapists contribute respect for the patient and continuity in the relationship which builds security for the patient. In addition, therapists contribute to a collaborative alliance by establishing and maintaining a positive balance in the alliance, and by restoring this when it becomes negative. This happens both through therapists resolving their own problematic countertransference feelings and through addressing the patient's difficulty with establishing and maintaining the alliance. Therapists contribute to collaboration by eliciting the patient to work together with them.

Second, interventions by therapists are most effective when they are accurately matched with the needs of patients and when the therapeutic

approach is consistent and focused. Consistent or pure therapy, that is, therapy that remains within one theoretical model, and helping a patient to understand the processes and participate in a focused way, are both related to positive outcome. Effective therapy addresses patient needs and adjusts to the developmental level of the patient, being more supportive and externally focused (anxiety suppressing) for patients lower in psychological functioning, and more exploratory and internally focused (anxiety eliciting) for patients higher in psychological functioning. Interventions are most effective and congruent when they take into consideration the individual differences of patients. These differences include factors such as the patient's perception of the therapists' intentions, the patient's state or current level of personal experiencing at the time of the intervention, and again, the development level of the patient. Congruence appears to be more important than the type of intervention itself.

Third, interpretations as a specific type of intervention are effective under certain conditions. When congruent they appear to be effective in increasing the level of patient experiencing and relaxation as well as the patient's capacity to benefit from the helping aspect of interpersonal relationships. In essence, interpretations affect the patient's awareness of themselves, improve their view of the therapist as helpful, and in turn positively affect the patient's capacity to enter relationships in a deeper way. Interpretations have been also found to increase patient levels of boldness and insight. New insight or understanding by patients, as a result of interpretations, has been correlated with positive outcome. The main types of interpretations studied are those that concern the patient's intrapsychic processes, including affect, defenses, and conflicts; and those that concern the patient's relationships, including early family, current significant, and therapeutic relationships. Interpretations concerning the patient's

relationship with the therapist, called transference interpretations, have been found more effective when patient experiencing of the relationship is high. Interpretations of intrapsychic processes have been found more effective when this higher level of transference experience is not present. The evidence is not yet sufficient to determine if effective transference interpretation leads to symptom or global improvement with the patient's presenting problem.

In studies of transference interpretations some additional principles emerge. First, the patient's early and consistent response to a transference interpretation is correlated to outcome: negative response to negative outcome and positive response to positive outcome. Second, when the transference interpretation disconfirms the patient's pathologic conviction that the therapist will respond in a negative or hurtful manner as expected by the patient, then it is more effective in helping the patient work toward their treatment goals. Third, there is evidence that transference interpretations are most effective, and sometimes only effective, with patients who have higher levels of interpersonal functioning. Patients without an increase in the level of experiencing, and the accompanying anxiety that is created in the process, are less able to tolerate transference interpretations. For these patients, it is more helpful to focus on exploring the patient's present affect and reaction to experiences than on transference patterns and feelings. Finally, it is the correspondence or congruence of the transference interpretations that allow for effectiveness, not the frequency or concentration. In fact, high concentration may weaken alliance even among patients with higher levels of psychological functioning. Research has demonstrated that transference interpretations are an effective form of intervention when applied according to these principles.

Substantive Conclusions

The research on psychotherapy process indicates several themes, each varying in degree of importance in terms of their contribution to psychotherapy outcome. First, an active and collaborative involvement in therapy by patients, and the patient's positive experience of the therapist's relationship qualities are essential for successful psychotherapy outcome. Second, establishing and maintaining a strong working alliance between patient and therapist is necessary for successful therapy outcome. Third, therapists contribute to successful outcome through offering a relationship based on warmth, friendliness, genuine caring, understanding, and acceptance. In addition, therapists use skills to illicit involvement by patients in the alliance, and use skills to facilitate maintaining the alliance.

Finally, therapists can further facilitate successful outcome by providing a consistent and purposeful approach and by considering the level of psychological maturity of the client. For patients with lower levels of psychological development, a supportive, focused, and concrete approach to the patient's problems is most helpful. For patients more psychologically mature, a focused approach continues to be important along with an effort to help patients explore thoughts, feelings, and dynamic patterns that underlie their problems. This exploratory process leads to insight and change by patients. Interpretation of intrapsychic and interpersonal dynamic patterns is helpful if the interpretation is appropriately timed to correspond with present, in-session experiencing by patients. Interpretation need not be a frequently used intervention to be effective, in fact, interpretation may be more effective when used with low frequency.

Since research to date indicates that patient involvement, therapy alliance, therapist offered relationship, and exploratory processes all contribute to outcome, future research should continue to focus on these areas. There are indications in the research that these four variables have varying degrees of importance in terms of their positive effect on therapy outcome. Consequently, to utilize resources most efficiently there should be certain priorities in future research. First, there are several studies that indicate that patient involvement accounts for the largest percentage of variance in relation to positive therapy outcome. Current research also identifies specific aspects of patient involvement, primarily in the area of patient characteristics or in the area of patient in-session functioning, that contributes to positive outcome. Future research should further identify and clarify these aspects of patient involvement. It should also attempt to identify the relative importance of these aspects. From this further refinement of the data, research could then focus more on the aspects of therapist functioning that correlate most significantly with patient involvement. To have functioning that most positively affect outcome, and to have information on the aspects of therapist functioning that correlate with these patient aspects, would advance the field of training and practice of psychotherapy.

The same research approach would apply to the therapy alliance variable. Research should continue to focus on specific aspects of positive and negative alliance behaviors on the part of both patients and therapists. The focus then could be on further identifying aspects of therapist functioning that best correlate with patient positive alliance behaviors, and that correlate with establishment and maintenance of therapy alliance. While it can be helpful to further study particular interventions by therapists and their direct correlation to outcome, it appears that a better use of resources would be to link therapist functioning,

including the use of specific interventions or techniques, to patient involvement and to the building and maintenance of therapy alliance. This approach would follow more closely the current indications of research. In addition, a research approach in the manner suggested here would eventually build a consistency of definitions of variables, particularly definition of specific aspects of patient involvement, therapy alliance, and therapist offered relationship. At this point lack of consistent definition of variables is a limitation for drawing practical conclusions from the research.

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